Washington, D.C. May 22-24, 2024

Medication Administration Record (MAR) **ONE medication per form**

Student Information

Student Name		DOB
School	Year	
Known Allergies	Height	Weight

Prescriber Information

Licensed Health Provider **Sign**

Name of Medication **ONE** PER FORM		Reason for Use
Dosage	Route	Frequency
Special Instructions		
Prescriber Signature		Phone
Prescriber Name (print)	Date	Fax

Parent/Guardian Authorization

Parent Sign

☑ I authorize an employee of the school board to administer the above medication. ☑ I authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order.

☑ Medication form must be received by the principal, designee, and/or the school nurse. ☑ I understand the medication must be in the original container and be properly labeled with the student's name, name of medication, dosage, and strength.

Parent/Guardian Signature	Date	#1 Contact Phone	#2 Contact Phone

Parent/Guardian Self-Carry Authorization (if applicable)

☐ ***For Epinephrine Auto Injector:*** *As the parent/guardian of this student, I authorize my child to possess and use an epinephrine auto injector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.*

☐ ***For Asthma Inhaler:*** *As the parent/guardian of this student, I authorize my child to possess and use an asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.*

Parent/Guardian Signature	Date	#1 Contact Phone	#2 Contact Phone

*************STAFF USE ONLY Medication Documentation Record (MDR) STAFF USE ONLY*************

Month	**May**		
Day	**22nd**	**23rd**	**24th**
Time given and initials			

Nurse/Staff Signature _____ **Initials** _____

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Medication Administration Guidelines

These are the guidelines for medication administration in the Poland schools as reflective of Board Policy 5330 & Ohio Revised Code 3313.

- **ALL** MEDICATION must be delivered to the school by a parent/guardian in the **original container** labeled with the student's name. Medications that are not in the original container **WILL NOT BE ACCEPTED**.

- **ALL** MEDICATION, **BOTH prescription and over-the-counter** must be accompanied by a medication form that has been signed by **BOTH** Licensed Health Care Provider (Doctor-MD/DO, dentist, orthodontist, CNP, or PA), **AND** the parent/guardian.

  Forms are available on the school website or in the school clinic.
  Only ONE medication can be listed per form.
  Medication forms are VALID ONLY for the current school year.

- Students are **not permitted to carry ANY** medications in school, unless it is an Epinephrine auto-injector or rescue inhaler (a signed medication form must be on file in the school clinic).

ANY QUESTIONS OR CONCERNS PLEASE CALL:

Holly Lefoer: PSJSHS (330)757-7018,#6, or extension 37334
School Nurse